STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

DEPARTMENT OF SOCIAL SERVICES
744 P Street, Sacramento, CA 95814

November 4, 1997

ALL COUNTY INFORMATION NOTICE I-69-97

TO: ALL COUNTY WELFARE DIRECTORS

REASON FOR THIS TRANSMITTAL

[ ] State Law Change
[ ] Federal Law or Regulation Change
[ ] Court Order or Settlement Agreement
[ ] Clarification Requested by One or More Counties
[X] Initiated by CDSS

SUBJECT: CHANGE ON THE SOC 432 CLAIM FOR REIMBURSEMENT CONTRACT EXPENDITURE FORM TO IMPLEMENT INCREASE IN FEDERAL MEDI-CAL ASSISTANCE PERCENTAGE

Effective October 1, 1997, there was an increase in the Federal Medi-Cal Assistance Percentage (FMAP). FMAP determines the Federal share of Medicaid benefit costs as well as establishing the federal share for the Foster Care, Adoption Assistance, Child Support, and In-Home Supportive Services (IHSS) Programs. This increase will effect the federal financial participation amount for the percentage of cost reimbursement for the Personal Care Services Program (PCSP). The federal sharing ratios will increase from 50.23 to 51.23 percent.

Due to this increase, it was necessary to revise the attached SOC 432 Claim for Reimbursement IHSS Program Contract Expenditures form. The sharing ratios for the remaining 48.77 percent (non-federal) for the PCSP services allocation will remain at 65 percent for the State and 35 percent for the County. The Non-PCSP sharing ratios for State and County will also remain the same.

Please feel free to make copies of the revised form for distribution to your county staff or you can contact the Department's Forms Management Branch at (916) 657-1984 and request a "Camera Ready" copy.

Counties should contact their assigned Fiscal Analyst to clarify or address any questions regarding the content of this notice.

Donna L. Mandelstam

DONNA L. MANDELSTAM
Deputy Director
Disability and Adult Programs Division

Attachment

CLAIM FOR REIMBURSEMENT
IN-HOME SUPPORTIVE SERVICES PROGRAM
CONTRACT EXPENDITURES

To: Adult Services Management Branch
California Department of Social Services
744 P street, MS 19-96
Sacramento, CA 95814

FROM:	
COUNTY:	
ADDRESS:	
CONTACT PERSON:	
PHONE NUMBER:	( )

CONTRACT NUMBER	CONTRACTOR NAME	SERVICE MONTH/YEAR

CONTRACT SERVICE DELIVERY TOTALS FOR MONTH BY FUNDING SOURCE:

WARRANT DATE _____

FISCAL YEAR/QTR. _____

FUNDING SOURCE	TOTAL CASES	TOTAL HOURS	GROSS EXP.	*ADJUSTMENTS	TOTAL NET EXP.
PCSP					
Non-PCSP					
Totals					

* If the actual PCSP and Non-PCSP adjustment amounts are not known, please estimate the PCSP and Non-PCSP amounts based on the PCSP and Non-PCSP hours to total hours ratio.

COST REIMBURSEMENT DETAIL BY FUNDING SOURCE:

FUNDING SOURCE	FEDERAL	STATE/COUNTY	STATE	COUNTY	TOTAL NET EXPENDITURE
PCSP	(51.23%) _____	(48.77%) _____	(65%) _____	(35%) _____	
Non-PCSP		_____	(65%) _____	(35%) _____	
Total	_____	_____	_____	_____	

I hereby certify, under penalty of perjury, that I am the official responsible for the administration of the Personal Care Services Program; that I have not violated any of the provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Section 1090 to 1096, inclusive of the Government Codes; that the amounts claimed herein are properly claimable as expenditures for the administration of the project as specified in accordance with all provisions of the Welfare and Institutions Codes, the rules and regulations of the State Benefits and Services Advisory Board.

SIGNATURE OF COUNTY WELFARE DIRECTOR OR CONTRACT ADMINISTRATOR	DATE

I hereby certify under penalty of perjury, that I am the official responsible for the examination and settlement of accounts, that I have not violated any provisions of federal law (Section 440.170(f) of Title 42 of the Code of Federal Regulations) Personal Care as a benefit; Section 14132.95 Welfare and Institutions Code personal care services as a benefit for the categorical eligible; and the provisions of Sections 1070 to 1096, inclusive, of the Government Code; that the expenditures claimed herein have been authorized, that a clearly delineated audit trail is in place to substantiate said expenditures, and that payments therefore have been made or expenditures otherwise incurred according to law.

SIGNATURE OF COUNTY AUDITOR OR CONTROLLER	DATE

Approved by: _____ Date _____

(State IHSS Program Manager)

SECTION I OVERPAYMENTS/UNDERPAYMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
A	PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
B	CONNECTED PAYMENT	(1)	(2)	(3)	(4)	(5)	(6)
C	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION II OTHER _____ (COUNTY SPECIFIC)

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
D	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
E	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
F	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION III LIQUIDATED DAMAGES

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
G	BILLED	(1)	(2)	(3)	(4)	(5)	(6)
H	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
I	NET BILLED	(1)	(2)	(3)	(4)	(5)	(6)

SECTION IV PCSP / IHSS ADJUSTMENTS

		PCSP CASES	IHSS CASES	PCSP HOURS	IHSS HOURS	PCSP GROSS	IHSS GROSS
J	NET ADJUSTMENT C + E + H (+ / =)	(1)	(2)	(3)	(4)	(5)	(6)
K	ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)
L	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)

SECTION V CONTRACTOR BILLING

	SERVICE MONTH (1)	TOTAL PCSP CASES	TOTAL IHSS CASES	TOTAL PCSP HOURS	TOTAL IHSS HOURS	TOTAL PCSP GROSS	TOTAL IHSS GROSS
M							
N	INVOICE BILLED	(1)	(2)	(3)	(4)	(5)	(6)
O	NET ADJUSTMENT + / = C + E + H OR L	(1)	(2)	(3)	(4)	(5)	(6)
P	TOTAL NET ADJUSTMENT + / =	(1)	(2)	(3)	(4)	(5)	(6)